DSS-AA-633E-04/98

STATE OF SOUTH DAKOTA
DEPARTMENT OF SOCIAL SERVICES

ORAL REQUEST FOR ADMINISTRATIVE HEARING
ADULT SERVICES AND AGING

Date of Request: _____

Name of Person Making Request: _____

Address of Person:

Telephone Number: _____

Lawyer or Other Representative (if known): _____

CID Number: _____

Program: _____

Issue:

DSS Action/Date _____

☐ I want my benefits to continue the same as before this Notice during the appeals process.

☐ I want my benefits to change as indicated on this Notice during the appeals process.

Submitted by:

_____
Social Worker

_____
Supervisor

_____
ASA Office

Received by DSS Office of Secretary: _____

Sent to OAH: _____